

## Block 1



### 12 Month Follow-up Questionnaire

**For assistance with completing this questionnaire please contact the SOS trial team on 02476 151 738**

By completing this online questionnaire you are confirming that you agree and understand that this data will be stored on Qualtrics. Qualtrics is a third-party company which has legal agreements in place with the University of Warwick and has been through strict information security assessment.

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TNO (this can be found in the text message with the link to the questionnaire)

Please let us know the date you are completing this questionnaire:

Please let us know who will complete this questionnaire:

The patient alone

The patient with help from relative/friend/carers

Relative/friend/carers on behalf of the patient

In this questionnaire, we use the words **“you” and “your”** referring to the **person who sustained the brain injury**. Some people in this study may have a medical condition or disability that would prevent them to fill in these questionnaires themselves. In that case, a relative/friend/ carer can fill out the questionnaires, however the words “you” and “your” still refer to the **person who sustained the brain injury** and not to the person helping/assisting in filling out the questionnaires

## Block 2

For each question please select the response that best describes your answer by marking the appropriate box.

### Part 1. Consciousness

#### **A. Are you able to obey simple commands or say any words?**

Note: obeying commands is considered anyone who shows the ability to obey even simple commands or utter any word or communicate specifically in any other way. Eye movements alone are not reliable evidence of meaningful responsiveness.

NO

YES

## Block 3

### Part 2. Independence at home

## **A. Is the assistance of another person at home essential every day for some activities of daily living?**

Note: for a NO answer you should be able to look after yourself at home for 24 hours if necessary. Not requiring assistance means that you have the ability to plan for and carry out the following activities: getting washed, putting on clean clothes without prompting, preparing food for themselves, dealing with callers and handling minor domestic crises. You should be able to carry out activities without needing prompting or reminding and should be capable of being left alone overnight.

NO

YES

## **B. Do you need frequent help or someone to be around at home most of the time?**

Note: for a NO answer you should be able to look after yourself at home up to 8 hours during the day if necessary

NO

YES

## **C. Was assistance at home essential before the injury?**

NO

YES

## Block 4

### Part 3. Independence outside home

#### **A. Are you able to shop without assistance?**

Note: this includes being able to plan what to buy, take care of money yourself and behave appropriately in public.

NO

YES

#### **B. Were you able to shop without assistance before?**

NO

YES

## Block 5

### Part 4. Independence outside home - 2

#### **A. Are you able to travel locally without assistance?**

Note: you may drive or use public transport to get around. Ability to use a taxi is sufficient, provided that you person can phone for it yourself and instruct the driver.

NO

YES

**B. Were you able to travel locally without assistance before the injury?**

NO

YES

## **Block 6**

### **Part 5. Work**

**A. Are you currently able to work (or look after others at home) to your previous capacity?**

NO

YES

**B. How restricted are you?**

Reduced work capacity

Able to work only in a sheltered workshop or non-competitive job or currently unable to work

**C. Were you either working or seeking employment before the injury (answer is 'Yes') or were you doing neither (answer is 'No')?**

NO

YES

## Block 7

### Part 6. Social and Leisure activities

**A. Are you able to resume regular social and leisure activities outside home?**

Note: you need not have resumed all your previous leisure activities, but should not be prevented by physical or mental impairment. If you have stopped the majority of activities because of loss of interest or motivation, then this is also considered a 'No' answer.

NO

YES

## **B. What is the extent of restriction on your social and leisure activities?**

Participate a bit less: at least half as often as before injury

Participate much less: less than half as often

Unable to participate: rarely, if ever, take part

## **C. Did you engage in regular social and leisure activities outside home before injury?**

NO

YES

## **Block 8**

### **Part 7. Family and friendships**

## **A. Have there been psychological problems which have resulted in ongoing family disruption or disruption to friendships?**

Note: typical post-traumatic personality changes are: quick temper, irritability, anxiety, insensitivity to others, mood swings, depression and unreasonable or childish behaviour.

NO

YES

## **B. What has been the extent of disruption or strain?**

Occasional - less than weekly

Frequent - once a week or more, but not tolerable

Constant - daily and intolerable

## **C. Were there problems with family or friends before injury?**

Note: if there were some problems before injury, but these have become markedly worse since the injury then answer 'No' to question

NO

YES

Epilepsy

## **D. Since the injury have you had any epileptic fits?**

NO

YES



**E. Have you been told that you are currently at risk of developing epilepsy?**

NO

YES

**Block 9**

**Part 8. Return to normal life**

**A. Are there any other current problems relating to the injury which affect daily life?**

Note: other typical problems reported after head injury: headaches, dizziness, sensitivity to noise or light, slowness, memory failures and concentration problems.

NO

YES

**B. Were similar problems present before your injury?**

Note: if there were some problems before injury, but these have become markedly worse since injury then please answer 'No'

NO

YES

## Block 10

### Part 9. Return to normal life - 2

#### **A. What is the most important factor affecting your outcome?**

The effects of head injury?

Effects of illness or injury to another part of the body?

A mixture of these?

## Introduction



## Health Questionnaire

## English version for the UK

## Mobility

Please select the ONE box that best describes your health TODAY.

### MOBILITY

- I have no problems in walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

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## Self-care

Please select the ONE box that best describes your health TODAY.

### SELF-CARE

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

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## Usual activities

Please select the ONE box that best describes your health TODAY.

### **USUAL ACTIVITIES** (e.g. work, study, housework, family or leisure activities)

I have no problems doing my usual activities

I have slight problems doing my usual activities

I have moderate problems doing my usual activities

I have severe problems doing my usual activities

I am unable to do my usual activities

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## Pain / Discomfort

Please select the ONE box that best describes your health TODAY.

### **PAIN / DISCOMFORT**

I have no pain or discomfort

I have slight pain or discomfort

I have moderate pain or discomfort

I have severe pain or discomfort

I have extreme pain or discomfort

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## Anxiety / Depression

Please select the ONE box that best describes your health TODAY.

### ANXIETY / DEPRESSION

I am not anxious or depressed

I am slightly anxious or depressed

I am moderately anxious or depressed

I am severely anxious or depressed

I am extremely anxious or depressed

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## Block 11

- We would like to know how good or bad your health is TODAY.
- You will see a scale numbered from 0 to 100.
- 100 means the best health you can imagine.  
0 means the worst health you can imagine.

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## Block 12

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## Resource Use

### Resource Use Questions

Have you been discharged from hospital since your brain injury?

Yes

No

1. **In the last six months**, have you used any of the following hospital based care services **related to your brain injury** (for example, have you been admitted to hospital again or had an outpatient clinic appointment)?

a. Hospital inpatient stay

No

Yes - please write the total number of days spent

b. Hospital outpatient clinic

No

Yes - please write the total number of visits

c. Hospital accident and emergency department

No

Yes - please write the total number of visits

d. Other (please specify)

Please write the total number of visits/days spent for this service

## Block 14

2. **In the last six months**, have you needed residential nursing care (e.g. step-down facilities, community ward, nursing home)?

a. Community ward

No

Yes

a. Community ward

If yes, how many days did you spend receiving such care?

Was this NHS funded or privately funded (either out-of-pocket or through private insurance)?

NHS

Private

In the last three months, have you needed residential nursing care (e.g. step-down facilities, community ward, nursing home)?

b. Rehabilitation unit

No

Yes

b. Rehabilitation unit



If yes, how many days did you spend receiving such care?

Was this NHS funded or privately funded (either out-of-pocket or through private insurance)?

NHS

Private

In the last three months, have you needed residential nursing care (e.g. step-down facilities, community ward, nursing home)?

c. Nursing home/care home

No

Yes

c. Nursing home/care home

If yes, how many days did you spend receiving such care?

Was this NHS funded or privately funded (either out-of-pocket or through private insurance)?

NHS

Private

In the last three months, have you needed residential nursing care (e.g. step-down facilities, community ward, nursing home)?

d. Other (please specify)

Other

How many days did you spend receiving such care?

Was this NHS funded or privately funded (either out-of-pocket or through private insurance)?

NHS

Private

## Block 20

3. **In the last six months**, have you used any of the following *community* based health and social services (this includes any services that are not within the hospital for example, visits to the GP)?

a. GP, surgery visit

No

Yes - please write the total number of visits/contacts

b. GP, home visit

No

Yes - please write the total number of visits/contacts

c. GP, telephone contact

No

Yes - please write the total number of visits/contacts

d. GP, practice nurse

No

Yes - please write the total number of visits/contacts

e. District nurse, health visitor or member of the community health team

No

Yes - please write the total number of visits/contacts

f. Community physiotherapist

No

Yes - please write the total number of visits/contacts

g. Call to NHS Direct

No

Yes - please write the total number of visits/contacts

h. Call for an ambulance or paramedic

No

Yes - please write the total number of visits/contacts

i. Occupational therapist

No

Yes - please write the total number of visits/contacts

j. Social worker

No

Yes - please write the total number of visits/contacts

k. Counsellor

No

Yes - please write the total number of visits/contacts

l. Home help or care worker

No

Yes - please write the total number of visits/contacts

m. Day centre

No

Yes - please write the total number of visits/contacts

n. Lunch or social club (organised by health or social care providers)

No

Yes - please write the total number of visits/contacts

o. Food, medicine or laundry delivery service (organised by health or social care providers)

No

Yes - please write the total number of visits/contacts

p. Family or patient support or self help groups

No

Yes - please write the total number of visits/contacts

q. Other (please specify, for example have you had any telephone consultations with your GP):

If other, please write the total number of visits/contacts

Special Equipment or aids

4. Have you used any special equipment or aids provided by health or social services or other providers to help you **in the last six months** (e.g. wheelchair, stair handrails)?

No

Yes

4.1 If **yes**, please describe below the equipment or aids provided to you, and any costs incurred for their use.

	Description of equipment or aid used	Who provided it? (e.g. health services, social services, self)	Cost to you £ (if none, please write '0')
1.			
2.			
3.			
4.			
5.			
6.			

Block 22



5. Are you in regular work (this includes full or part-time, paid or unpaid e.g. as an unpaid carer)?

No

Yes

5.1 If yes, how many days were you unable to work because of health problems **in the last six months?**

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